EXHIBIT B

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

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DR. PAUL M. CONTI,

Plaintiff, Case No.

- against - 17-CV-9268

JOHN DOE,

Defendant.

----------x

DEPOSITION OF PAUL S. APPELBAUM, M.D.

New York, New York

Tuesday, January 21, 2020

9:38 a.m.

Reported by:

ERICA L. RUGGIERI, RPR

JOB NO. 3850032

January 21, 2020

9:38 a.m.

Deposition of PAUL S. APPELBAUM, M.D., held at the offices of Judd Burstein, P.C., 5 Columbus Circle, Suite 1501, New York, New York, pursuant to Notice, before Erica L. Ruggieri, Registered Professional Reporter and Notary Public of the State of New York.

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S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED, by and between the attorneys for the respective parties herein, that filing and sealing be and the same are hereby waived.

IT IS FURTHER STIPULATED AND AGREED that all objections, except as to the form of the question, shall be reserved to the time of the trial.

IT IS FURTHER STIPULATED AND AGREED that the within deposition may be sworn to and signed before any officer authorized to administer an oath, with the same force and effect as if signed and sworn to before the Court.

PAUL S. APPELBAUM, M.D.

P A U L S. A P P L E B A U M,

called as a witness, having affirmed, was examined and testified as follows:

EXAMINATION BY

MR. BURSTEIN:

Q. Good morning, Dr. Appelbaum.

A. Good morning.

Q. I know that you've been deposed before from your report but...

MR. BURSTEIN: Usual stips by the way?

MS. ROSENFELD: Federal court.

MR. BURSTEIN: Right. You know, basically the rules. He doesn't have to sign in the presence of a notary. Even though it's all objections except for -- all objections other than form are reserved. Basically the normal stuff.

MS. ROSENFELD: Right. And we

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messages that is the focus of this litigation, and for the purposes of this question I'm going to ask you to assume that there are e-mail messages of the type that are at issue in this case?

MS. ROSENFELD: Objection to form.

Q. And is there -- are there any peer-review articles discussing issue number one that you are aware of?

MS. ROSENFELD: Objection to form.

A. Not that I'm aware of as I sit here today.

Q. Are there any rules of conduct issued by a psychiatric organization that specifically addresses issue number one?

MS. ROSENFELD: Objection to form.

A. I'm not aware of written rules that specifically address

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responding to text and e-mail messages of this sort.

Q. Okay. Are you aware of any generally accepted standard within the psychiatric community for addressing the issue raised -- that you opined on in number one?

A. Yes. I think there are generally accepted standards in psychiatry today.

Q. And what are those standards?

A. Those standards are that a psychiatrist in responding to patient communications, whether they are text, e-mail, phone calls or face-to-face communications needs to attempt to understand them in the context of the treatment and the patient's condition, not necessarily taking them at face value but assessing them with regard to the nonverbal as well as the verbal aspects of the communication, that

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is what the latent meaning of these communications may well be. And in responding doing so in a way that's consistent with the overall thrust of the treatment.

Q. Is that generally accepted standard also applicable to psychiatrists who are -- who have terminated treatment where the patient has new therapists, whether it be psychiatrists or psychologists?

A. So I think a psychiatrist has an ongoing obligation not to undermine the previous treatment or otherwise endanger the well being of a former patient, whether or not that patient has linked up with a new treater.

Q. And is it your view that the psychiatrist's duty with respect to the standard of care that you've just identified is the same whether the psychiatrist is treating a

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current patient as opposed to a psychiatrist who is no longer treating the patient?

MS. ROSENFELD: Objection to the form.

A. Although there are clearly differences with regard to the responsibility of a psychiatrist for a former patient compared with a current patient insofar as the specifics of what I just described are concerned, which is to say not responding in a counter-therapeutic way and keeping in mind the long term welfare of the patient, I don't think there are significant efforts as before and after termination.

Q. Are you aware of any scholarly articles that are peer reviewed addressing the issue of a psychiatrist's obligation to interacting with prior patients?

A. I think there are articles that speak about some aspects of

those obligations but I'm not aware of any that speak -- well, let me back up and say it in a clearer way.

There are certainly writings that speak to the general principle not undermining the previous treatment and not injuring the patient deliberately in any way, that is having the patient's welfare in mind even when the patient becomes a former patient, and there are a variety of specific ways in which that general principle plays out. I'm not aware of anybody who has written specifically about responding to text and e-mail messages but I think the general principle is there and is clear.

Q. Are there any peer review articles addressing a psychiatrist's obligation post termination of the patient when the -- when a patient sends threatening e-mails and texts?

A. I'm not aware of such an

article.

Q. Are there any generally accepted standards, other than the general one that you just identified, to deal with the specific issue of a patient who is no longer treated by the psychiatrist sending threatening texts and e-mails?

MS. ROSENFELD: Objection to form.

A. I think that I would respond as I did previously, which is to say there are general principles that govern post termination relationships and that that is what would be applied to this circumstance. I'm not aware of peer review articles that have considered that specifically but I think the general principles have certainly been addressed.

Q. Just to be clear, there's no standards issued by any

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recognized standards or rules issued by any recognized professional organization such as the APA which address that specific issue?

MS. ROSENFELD: Objection to the form.

A. I'm not aware of specific writings from APA that have addressed that narrow issue as opposed to the broader principles.

Q. Or any -- other than general principles, any generally accepted practice with respect to that specific issue --

MS. ROSENFELD: Objection to the form.

Q. -- of post termination threatening e-mails and texts?

A. So I think the generally accepted practice is to behave in a way that is consistent with those principles I described.

Q. And now drilling down to the individual therapist applying

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these principles, does the application of those principles involve the exercise of judgment by the treating psychiatrist?

A. I think in part it does.

Q. And is it your view that a psychiatrist presented, for example, with hostile texts that there is only one response that would be professionally responsible in those circumstances?

A. Given that there will be a large number of contingencies surrounding any particular case, I think those contingencies need to be taken into account. I'm not prepared to say there's just one right response.

Q. Are you aware of any psychiatrist who has been punished or sanctioned by state authority for the manner in which he responded to threats by a patient?

A. No. But I would not

necessarily know if it had happened because I certainly don't track every disciplinary action by every state medical board.

Q. Are you aware of any -- is there a -- does the APA, for example, have a disciplinary committee?

A. The Ethics Committee -- let me say it differently. The APA has a disciplinary structure which involves both the district branches, roughly the state societies, although some states like New York have multiple district branches, as well as the national Ethics Committee.

In general, disciplinary proceedings are initiated at the state level and then can be appealed to the national level. There was previously something called the Ethics Appeals Board which I chaired for two years that handled those

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Are there any peer review articles of which you are aware which address issues -- I did a terrible job again. I'm sorry. One more time.

Are you aware of any peer review articles which address a physician's right to commence litigation against a patient?

MS. ROSENFELD: Objection to form.

A. There are articles or books that touch on the question that have redress for nonpayment which consider a range of options which the ultimate one is a lawsuit. I'm not aware of peer review articles that address any other instances related to lawsuits against former patients.

Q. Okay. Are you aware of any rules or standards issued by any recognized association, such as the APA, which addressed the issue of a physician's right to commence

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litigation against a client for reasons other than fees?

A. No. But given that it's such an extraordinary situation I'm also not surprised that there are not standards which generally deal with more common circumstances.

Q. And I take it then that there's also no generally accepted standard within the psychiatric committee -- community addressing the issue of a physician's right to commence litigation against a client for a reason other than nonpayment of fees?

MS. ROSENFELD: Objection to the form.

A. So I would respond as I did before by saying there are, as in much of psychiatric practice, general principles that should be applied. We discussed briefly what I think those principles are. But not specific application of those

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principles to the issue that you are asking about, namely commencing a lawsuit.

Q. Are you aware of any peer review articles, slightly different question, which address the issue of ethical limitations on a psychiatrist's right to sue a patient for harassing or abusive behavior?

A. I'm not.

Q. And is your answer the same with respect to standards, ethical standards or rules issued by a recognized psychiatric association?

MS. ROSENFELD: Objection to the form of the question.

A. If you are asking whether they specifically address suing former patients, my answer is no, I'm not aware of anything that specifically addresses that unusual issue.

Q. Are you aware of any state

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authority or any -- any state authority issuing a ruling or discipline because -- from the fact that a psychiatrist commenced a proceeding against a patient for a reason other than nonpayment of fees?

A. I am not.

Q. Are you aware of any state medical board or court issuing a ruling concerning limitation -- issuing that, sort of the same question, issuing a ruling that a psychiatrist acted improperly in commencing a lawsuit against a patient?

MS. ROSENFELD: Object to the form of the question.

A. No. But I'm also not aware of any other psychiatrist who has ever sued a former patient other than for nonpayment of fees.

Q. Okay. Do psychiatrists -- are you aware of any court decisions

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Q. Moving on to number three, "safeguarding Doe's confidence and privacy when he did choose" the initiation -- "to initiate litigation." I'm going to address that later because there are standards and ethical rules concerning that issue, right?

A. Yes.

Q. But are there any such standards or articles addressing the question of safeguarding confidences and privacy when a psychiatrist sues a patient for reasons other than nonpayment of fees?

MS. ROSENFELD: Objection to the form.

A. Again, I would say that that is so unusual and perhaps unique a situation that I wouldn't expect such things to exist and to my knowledge they don't.

Q. Okay. Let's move on. If we go back to paragraph 3 of PA-1.

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was filed on January 5th, 2018. Do you see that?

A. Yes.

Q. Okay. But you refer to -- that the complaint that was filed on November 27, 2017 -- do you know where you found that date?

A. I do not know where that came from.

Q. Okay. Are you aware of how the process by which -- well, withdrawn.

As you see from PA-3, it's entitled Anonymized Complaint. Do you see that?

A. Yes.

Q. Are you aware of the process by which this complaint was filed as an Anonymized Complaint?

A. I am not aware of any of the details of the process.

Q. Do you have any knowledge as to whether or not Mr. -- there was a complaint which identified

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A. After his evaluation.

Q. How much time?

A. Probably approximately half an hour.

Q. I'll go back to this but do you recall what you discussed with Dr. Cohen?

A. In general terms I asked him for his assessment of the evaluation and to summarize what he had learned and concluded.

Q. And what did he tell you, to your recollection?

A. He told me that he thought Dr. -- as best I recall, that he thought Dr. Conti had exaggerated the threat from the patient, that he was clearly extremely angry at the patient and that he had acted on his anger in the subsequent events, which included the filing of this lawsuit.

Q. Did he explain his reasons for believing that Dr. Conti I think

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you said over estimated the threat?

A. Yes.

Q. And what reasons did he give you?

A. My yes was to the language of overestimating the threat.

MS. ROSENFELD: It was actually exaggerated.

MR. BURSTEIN: Exaggerated. Thankfully you have a better memory than I do.

A. So he did not tell me on that phone call in any great detail what the explicit basis was for his belief that Dr. Conti had exaggerated the threat.

Q. Do you recall whether or not you had reviewed the -- Dr. Hamilton's psychiatric treatment records of Dr. Conti before March of 2019?

A. I don't recall.

Q. Okay. I'm sorry, I forgot your answer about whether or not you

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major impressions.

MR. BURSTEIN: If I could just ask one question.

MS. ROSENFELD: That's fine. I didn't mean you needed to stop at this --

Q. Do you recall what impressions you had about John Doe upon reviewing his patient file and billing records from Dr. Conti and his associated mental health professionals?

A. I had the general sense that he was not an easy patient to treat. He had been through multiple treatments before. Clearly he had come in with a history of difficult family relationships and sort of tumultuous life events and even during treatment continued with a pattern of tumultuous events.

Q. And did you come to, let's say, any preliminary conclusions about what an appropriate diagnosis

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of John Doe would be vis-à-vis his psychological issues?

A. So apart from his Xanax addiction which everybody agrees was present and the fact that he manifested characterological problems of a variety of sorts, I'm not comfortable even today putting a specific label on his diagnosis. I think it's a sufficiently complex case that without having evaluated him face-to-face, even having read the notes and his deposition and the depositions of people who knew him or who treated him, that I'm not prepared to diagnose him.

Q. Were you aware that in the context of this case a psychiatrist retained by John Doe's -- by my side examined John Doe?

A. Yes.

Q. Did you read that report, his report?

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read the counterclaim, the answer and counterclaim, Exhibit 13, before you wrote your final -- you completed your report?

A. I don't remember.

Q. You were asked in SA-1 to render an opinion about the ethical issues in this case. Do you recall which ethical issues were identified to you as issues you should review?

MS. ROSENFELD: You can answer, but to the extent it involves disclosing the content of our conversations you can't discuss that.

MR. BURSTEIN: That's not really privileged. He was retained to express opinions about ethical issues. I'm entitled to ask what he understood those issues to be.

MS. ROSENFELD: That's fine. He can answer that question to the extent he's not disclosing the content of our conversation.

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A. I understood those to be whatever issues I could identify, if there were any, related to Dr. Conti's initiation of the lawsuit against the patient.

Q. Do you know whether or not all -- whether or not John Doe has sought damages for what you allege -- for all of what you have opined are ethical violations by Dr. Conti?

MS. ROSENFELD: Objection to the form.

A. I don't know enough about his claim to answer that.

Q. Now, if we go to Section 2 of your report, Applicable Standard for Ethical Conduct of a Psychiatrist. You refer to the APA Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, correct?

A. Yes.

MR. BURSTEIN: Mark this PA-5.

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(Exhibit PA-5, American Psychiatric Association, The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, marked for identification, as of this date.)

Q. Looking at PA-5, it's a document entitled American Psychiatric Association, The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry.

Is that the document that you refer to in your report in Section 2?

A. Yes.

Q. In says 2013 edition. Do you know whether or not there's a newer edition of the Principles of Medical Ethics?

A. I'm not aware whether there's a newer edition, although this would have been the edition that was offered up at the time of

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the events involved in this case.

Q. Have you -- did you review any other documents containing ethical rules governing a psychiatrist's conduct before -- in reaching your opinion?

A. No.

Q. Did you review any statutory statutes governing the issues -- governing a psychiatrist's conduct with respect to the issues on which you opined in your report?

A. No.

MS. ROSENFELD: Objection to the form.

Q. Did you review any decisions of a medical board or other or other state administrative body addressing the issues that are identified in your report as the ones you opined on?

A. No.

Q. Is there a reason why you did not do that?

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A. Insofar as I was asked to testify to the ethical issues as I saw them in this case, the guiding principles of medical ethics for psychiatrists are embodied in this document and I didn't see a need to explore elsewhere.

Q. And if we look at paragraph, Section 2, paragraph 5 of your report, you list a number of annotations to Section 4 of the principles.

A. Correct.

Q. And you do not refer to any other sections of the principles in your report, correct?

A. That's correct.

Q. And if we could look at PA-5, Section 6, I want to read it to you. "A physician shall in the provision of appropriate care, except in emergencies, be free to choose whom to serve with whom to associate and the environment in

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think that this provision says that.

Q. That's your interpretation of this provision, would that be fair to say?

A. I think you and I may have different interpretations.

Q. But as a matter of English language, would you agree that I have characterized the facial meaning of this?

MS. ROSENFELD: Objection to the form.

A. No, I don't.

Q. All right. Is it your opinion that it is per se unethical for a psychiatrist to sue a patient based upon the receipt of threats or other abusive conduct by a patient?

A. No.

Q. Do you believe that a psychiatrist's duty to patients trumps his right as a citizen to sue a patient?

MS. ROSENFELD: Objection to

there's a great deal of literature and a general acknowledgement that it is not always easy to perform an accurate assessment of the degree of risk and that there is a tendency for a variety of reasons to overestimate the degree of risk and it is an area of ongoing active research.

Q. You've, in fact, written on this issue a number of times, correct?

A. Yes.

Q. And you, in fact, have offered -- I may not be describing this correctly -- a form of matrix to assess risk of patients' threats?

A. Within the context of current knowledge, recognizing the uncertainties, yes.

Q. And has that matrix you've proposed been universally accepted by the psychiatric community?

A. I don't think anything is

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universally accepted by the psychiatric community.

Q. There are differences of opinion within the psychiatric community as to how a psychiatrist should assess the danger posed by a patient, right?

A. I think the difference is less about how to assess the risk because there's general agreement about what the major risk factors are based on the research than there is perhaps agreement about the degree to which those assessments can be relied upon.

Q. Would it be fair to say that there is a consensus within the psychiatric community that one important element of risk assessment is the clinician's judgment of the situation?

MS. ROSENFELD: Objection to the form.

A. I would frame that a little

assessment and that there may be other variables that need to be taken into account as well.

Q. Let me ask it a different way. Would you agree that three, I'll say three -- withdrawn.

Would you agree that two responsible psychiatrists take you and another psychiatrist you respect looked at the same facts and sought to analyze whether a psychiatrist's apprehension of fear and belief of threat was real was reasonable. You got that hypothetical?

A. Yes.

Q. Would you -- is it possible -- withdrawn.

I would agree that two responsible psychiatrists might look at the same facts and one might conclude that the treating psychiatrist's belief about the patient's danger was reasonable and another responsible psychiatrist

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might conclude that it was an unreasonable belief?

MS. ROSENFELD: Objection to the form.

A. I would hope that would not be the case. I think experienced psychiatrists who know the literature on risk assessment should be able to at least concur with regard to the general levels of risk whether this is a low, medium or high risk situation, there is in fact literature suggesting that when you group categories that way you get higher levels of agreement. I can't guarantee that any two people would necessarily agree. But if they are focused on the same information, they should agree.

Q. Well, let's take a Tarasoff situation. A patient -- a psychiatrist has received -- learns various facts from a patient, observes other facts, considers

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lawyers. I have also been told that there was a monetary demand that was made in that period of time.

Q. And no more details?

A. That's about what I know.

Q. Did you ask for -- to see any of those communications?

A. No.

Q. Well, would it not be relevant to you in assessing whether or not Dr. Conti overreacted to the threats from John Doe to examine whether or not he had first made efforts to avoid suing John Doe?

MS. ROSENFELD: Objection to the form.

A. So I think the overreactions came in the decision to view John Doe's communications as sufficiently serious to warrant the filing of a lawsuit. What transpired between the lawyers I don't know. I don't

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know if I have ever been privy to, as an expert, to communications among the lawyers in a case.

Q. Would be one way of -- would one way of interpreting your opinion is that a doctor suing a patient based upon threats made by the patient should be a remedy, if at all, remedy of last resort?

MS. ROSENFELD: Objection.

A. Yes, if at all a remedy of last resort.

Q. So engaging the reasonableness of the doctor's decision to employ the last resort, wouldn't it be relevant for you to assess the efforts that the doctor made to avoid taking that last step?

A. Arguably, depending on what they were.

Q. And you didn't do that in this case?

A. Well --

MS. ROSENFELD: Objection to

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the form.

A. I haven't had available to me the information about the communications between the lawyers.

Q. And you didn't ask for them?

A. If you want to present them to me and ask for my opinion, I'm happy to read them and give you my opinion.

Q. Well, let's look at --

(Exhibit PA-8, E-mail, marked for identification, as of this date.)

Q. This is an e-mail from me to then counsel for John Doe in November of 2017. Have you seen this document before?

A. No.

Q. But you've seen numerous -- withdrawn.

John Doe had sent Dr. Conti a number of texts after

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discussing this issue of psychiatrists, even in a therapeutic type setting, observing conduct that's in public or in front of a number of other people being bound by confidentiality in a litigation?

A. No, but I think it's a highly unusual circumstance.

Q. Would it be fair to say that this case itself is, in your experience, highly unusual?

A. I think there are many aspects of it that are highly unusual.

Q. But the fact that there's a litigation is highly unusual.

A. For a psychiatrist to have sued a patient is extraordinarily unusual.

Q. So would it be fair to say that there are -- there's no body of literature in the profession that has addressed the propriety of a client -- a patient -- a doctor

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suing a patient?

MS. ROSENFELD: Objection to the form.

A. There are not to my knowledge specific -- there is not specific literature that addresses doctors suing patients other than, as we said earlier, outside the billing context.

Q. In fact, in the billing context it's even ethically acceptable to provide patient information to a collection agency?

MS. ROSENFELD: Objection to the form.

A. Some information. Namely information about the patient's name, address, dates of service, charges, but certainly not information that was communicated within the -- within the treatment session.

Q. But in that circumstance the information that was provided --

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that what happened in the treatment session is really irrelevant to whether or not the money is owed?

A. True. And therefore is not disclosed.

Q. But certainly disclosing the patient's name and other identifying information and the fact that the patient was being treated can be disclosed for nonpayment of fees?

A. Yes.

Q. But it's your opinion that a doctor who sues because he believes he was threatened and also defamed, in particular believes he was defamed, violates confidentiality by suing even if he makes sure that the complaint is anonymized?

MS. ROSENFELD: Objection.

A. So not as a general matter, no. But in this specific case, yes.

Q. And it was an ethical

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violation because you don't think that the lawsuit was warranted?

A. It's an ethical violation because in bringing this suit Dr. Conti disclosed much more confidential treatment related information than was at all necessary for the purpose for which the disclosure was being made.

Q. So your view is not that he had no right to sue but that he divulged too much in the lawsuit?

MS. ROSENFELD: Objection.

A. Part of my opinion is certainly that. We have also talked about my opinion with regard to the accuracy of his assessment of the risk that he felt himself to be under. But assuming he was going to bring a suit, I think he had an obligation to do so in a way that was least revealing of the confidential treatment related information and he clearly failed to

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do that.

Q. How about a doctor's right to sue for defamation, do you believe a psychiatrist has the right to sue for defamation?

A. I think in theory, yes, done appropriately.

Q. And if a court were to conclude that an adequate case for defamation had at least been pleaded, would that provide a basis for concluding that the doctor had not acted improperly in bringing the action?

MS. ROSENFELD: Objection.

A. No. It would indicate that the court believed that at least the information necessary to plead a defamation claim had been brought but it doesn't speak to the question of whether much more information then was necessary for that was disclosed.

Q. That's not my question.

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I'm just asking you about the fact do you believe that the fact of suing for defamation is per se inappropriate?

A. No, I don't.

Q. And do you think that the fact that a court upheld a claim for defamation would be relevant to the determination of whether a doctor acted unethically in bringing the suit?

MS. ROSENFELD: Objection.

A. No. I don't think that that determines one way or the other whether the doctor acted unethically.

Q. So that how about if a doctor were to win a defamation suit, would that be relevant to whether or not the doctor had acted unethically?

A. No. I think it would speak to the strength of the legal claim but -- which would, as I was

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suggesting before, indicate that the doctor had brought at least that amount of information necessary to prove the claim, but it wouldn't speak to the ethical question of whether he had brought much more information than was necessary.

Q. I understand that. I'm trying to separate out these issues.

One is, which I'm not asking about right now, is whether the doctor put too much information in. I'm only asking about the question if he brought a complaint for defamation which met your standards of providing the minimal amount of information, would a court upholding a complaint for defamation under those circumstances in your view be an indication that the doctor had acted ethically?

MS. ROSENFELD: Objection.

A. No. I think the doctor either acted ethically or he didn't.

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He might win or lose the defamation claim but that is not material to the question of whether he behaved ethically or not.

Q. Just so I understand, it's your view that unlike other views in this country, psychiatrists or other doctors are ethically prohibited at times from pursuing claims that -- to protect themselves -- pursuing claims that -- for their own benefit to protect their rights?

MS. ROSENFELD: Objection.

A. No, I wouldn't say that at all.

Q. So you are saying that a doctor does have the right to bring a meritorious defamation case as long as he does not over-disclose?

MS. ROSENFELD: Objection to the form.

A. In the right circumstances, yes.

Q. Can you think of a

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circumstance where a doctor would be prohibited from pursuing a meritorious defamation case by reason of the ethical rules of misconduct?

MS. ROSENFELD: Objection.

A. Sure. Patient is manic or psychotic or both and tells other people that the doctor had abused him in some way, beaten him with a whip or hit him over the head with a chair, arguably a defamatory statement on the part of the patient. The psychiatrist's response to that should not be to sue the patient for defamation but to recognize that that's part of the patient's illness and to appropriately treat or continue treating that illness.

Q. Just so I understand it. So even if the manic patient managed to get a story into the New York Post that the doctor had sexually

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abused him, there should be no defamation claim?

A. Insofar as the behavior of the patient is a manifestation of the illness, the appropriate response is to treat the illness.

Q. So in your view in the hypothetical situation I have given you, the doctor should remain silent in the face of a false accusation of sexually assaulting a patient?

A. No, I mean I can't be that broad in a statement like that.

Q. You said a minute ago that if a patient makes an outrageous allegation and they are in a manic state, the doctor should not sue for defamation, should be doing dealing with it within the confines of the relationship.

I then asked you well, suppose the patient manages to get the story into the newspaper, perhaps because of who the patient is, and there's a

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page 3 story in the New York Post that this doctor whipped his patient. Is it your view that the doctor under those circumstances should remain silent and just allow that story to go unrebutted?

A. No, it's not my view that the doctor should remain silent and, you know, I will concede to you and I have said this clearly I think already, that there may be circumstances under which defamation claims are appropriate to pursue. But merely because a defamatory statement has been made is not necessarily one of those situations when there are other ways and better ways to deal with it within the framework of the treatment.

Q. Well, is there any standard expressed in ethical rules as to what the dividing line is between when it's appropriate for a psychiatrist to sue for defamation

and it's not appropriate for a psychiatrist to sue for defamation?

A. Not that I'm aware of because I have never before this case ever heard of a psychiatrist who sued a patient for defamation.

Q. In terms of the other steps that a psychiatrist might take, would seeking to find a pretrial resolution -- a prelitigation resolution of some kind be a step that a psychiatrist might take as in an effort to avoid making disputes public?

A. Yes.

Q. Okay. And that would in the abstract not be an unreasonable attempt to solve the problem of confidentiality?

A. In the abstract, no.

Q. It would be --

A. It would not be unreasonable.

Q. It would not be

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A. So the principle -- so I just want to clarify here --

Q. Or conduct.

A. Yeah, conduct. Principles are, you know, much, much broader and overarching. We are talking about specific behaviors.

Q. Spectrum of conduct. In your opinion, where on the spectrum of conduct, given that this is a unique circumstance, where in the spectrum of agreement on conduct would your opinion in this case lie?

A. I think you would find very substantial agreement among psychiatrists with regard to the opinions that I expressed in this case about the application of the ethics of psychiatry. To know for sure we'd have to go out and ask a lot of psychiatrists but that is my belief.

Q. Well, I just want to ask you a couple more questions. Do you

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have in your own mind an estimate of what percentage of the psychiatric community would agree with your conclusions?

A. No.

MS. ROSENFELD: Objection.

A. I can't give you a number.

Q. Is it your view that there would be -- would it be a plurality of psychiatrists who would agree with your conclusions?

MS. ROSENFELD: Objection.

A. I would think at the very least a plurality but -- indeed a majority, but I don't think I can put a number on that.

Q. Okay. It's because this situation is so unusual you really can't, so to speak, handicap how accepted your conclusions would be with respect to the facts of this case?

MS. ROSENFELD: Objection to the form.

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A. Well, so that's not what I said a few minutes ago. What I said a few minutes ago was I think my conclusions with regard to this case in fact would represent the views of a clear majority of psychiatrists and the dominant view in the profession.

Q. But that's based upon your --

A. My sense of the ethics of psychiatry and the ways in which those ethics are applied to specific questions in psychiatry.

Q. I'm going to ask a few more questions. We are getting to the end by the way. By the way, are there any rules -- are there any ethical principles about overcharging psychiatric patients?

A. Yes. Charges should be within a reasonable range and certainly patients should, particularly in vulnerable patients

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MR. BURSTEIN: Yeah, June 14, 2017, starting with June 14 of 2017.

Q. And if we look at the second page, Dr. Jenike -- Dr. Conti writes to Dr. Jenike, "I'm happy to talk to you and John Doe. Think that would be helpful to him."

Now, in the first instance we have agreed that the offers that Dr. Conti made in April on termination in his e-mail were appropriate offers?

A. Yes.

Q. And now, this is a couple months later and he writes, "I'm happy to talk if you and John Doe think that would be helpful to him. I would like a straightforward authorization from John Doe to do this."

That's nothing improper about wanting an authorization from John Doe, correct?

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A. Yes.

Q. In fact, it would be required?

A. Yes.

Q. "And I would also request authorization to bill for any time spent in clinical conversation."

Now, he then goes on to say, "I have spent a fair amount of unbillable time since we ended care and there is also a small outstanding balance from before which I would appreciate clearing."

Certainly it wasn't unreasonable for Dr. Conti to ask that a prior balance be paid?

A. No.

Q. Okay. And there was also no obligation for him to talk to Dr. Jenike, correct?

A. Correct.

Q. He could have just said I'm going to send the files, right?

A. Correct. Although I would

suggest that if upon receipt of the files Dr. Jenike then said thanks for the files but you know I have a couple of questions, can we talk on the phone, that there is an obligation to respond to questions.

Q. But that never happened in this case?

A. As far as I'm aware, no.

Q. And in fact, Dr. Jenike never even asked for Dr. Conti's files; isn't that correct?

A. I don't know the answer to that.

Q. And Dr. Conti -- do you read this e-mail saying that he would not speak to Dr. Jenike under any circumstances unless he was paid for his time?

A. That's how I read that.

Q. So when he says I would also request authorization to bill for any time spent in clinical conversation, he wasn't saying that

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he would not assist in transition, right?

A. I think what he's saying is if you want to talk to me on the phone, I want to be able to bill for that time.

Q. But he had no obligation to speak to him on the phone?

A. Well, he had an obligation to communicate the information.

Q. But he never said he wouldn't send his files to Dr. Jenike, did he?

A. He didn't offer to send those files in lieu of a person-to-person communication. What Dr. Jenike -- well, what he seems to be addressing here, whether it was at Dr. Jenike's request or at the patient's request, is the question of can we talk on the phone and you can tell me about your treatment of John Doe. And his response is, A, I want an